

OUTREACH REPORTING FORM FEBRUARY 2000

(Reporting forms should be included with Quarterly Reports)

1. DATE OF ACTIVITY:

2. TYPE OF ACTIVITY :	NLM SYSTEM SESSION OTHER INTERNET SESSION	TECHNOLOGY AWARENESS TRAIN THE TRAINER	OTHER (PLEASE SPECIFY):
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3. ASSOCIATION/INSTITUTION SPONSORING ACTIVITY:**4. ASSOCIATION/INSTITUTION CONDUCTING ACTIVITY:****5. OTHER COLLABORATING (OR COOPERATING) INSTITUTION:****6. LOCATION WHERE ACTIVITY OCCURRED:**

A. CITY

B. STATE

C. ZIP CODE

D. COUNTY

E. CONGRESSIONAL
DISTRICT**7. LENGTH OF ACTIVITY
(HOURS):****8. HANDS ON PRACTICE** YES NO

9. CEU	YES	NO
CME	YES	NO NOT APPLICABLE

10. SIGNIFICANT NUMBER OF MINORITIES PRESENT (>50%)	YES	NO
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11. NUMBER OF PERSONS WHO ATTENDED:**CATEGORY****AFFILIATED****UNAFFILIATED¹****UNKNOWN**

PHYSICIANS

NURSES

DENTISTS

ADMINISTRATORS (Hospital)

PHARMACISTS

ALLIED HEALTH PROFESSIONALS

LIBRARIANS

CONSUMERS

OTHERS (PLEASE SPECIFY IN BOX BELOW NUMBER

UNIDENTIFIED HEALTH PROFESSIONALS

TOTAL¹Unaffiliated is defined as lacking attending privileges at a hospital which has a medical library or not on the faculty (full-time, part-time adjunct or clinical) of a professional school.**12. NAME AND TELEPHONE NUMBER OF PERSON SUBMITTING FORM:**_____

DEFINITIONS

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